State of Georgia
Subsequent Injury Trust Fund
Annual Assessment Report – Self-Insurers

In accordance with O.C.G.A. 34-9-359 and the regulations of the Subsequent Injury Trust Fund, this report **must be received by the Subsequent Injury Trust Fund on or before March 1, 200_.** The report must cover all actual workers' compensation indemnity and medical payments for the period of one year, from January 1, 200_ through December 31, 200_, regardless of date of accident. This information is used to compute the Subsequent Injury Trust Fund assessment rate for calendar year 200_.

PENALTY FOR LATE FILING – REPORTS RECEIVED BY THE SUBSEQUENT INJURY TRUST FUND *AFTER* MARCH 1, 200_ SHALL BE SUBJECT TO A PENALTY OF *$50.00 PER DAY*, FOR EACH DAY THE REPORT IS DELINQUENT, OR *TEN PERCENT (10%) OF THE ASSESSMENT*, WHICHEVER IS GREATER. O.C.G.A. 34-9-359.

Reports will be considered timely received by the Subsequent Injury Trust Fund only if they are actually received in hand on or before the required due date OR bear a valid *US Postal Service* postmark on or before the required due date.

This report must be filed even if no workers' compensation benefits were paid during calendar year 200_.

WCB#
NAME, TITLE
COMPANY
ADDRESS
ADDRESS
CITY, STATE, ZIP

Please make any changes or corrections to recipient name or address.
Please notify the Subsequent Injury Trust Fund of any contact or address changes as they occur.

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\- CAREFULLY REVIEW THE INSTRUCTIONS ON THE REVERSE SIDE OF THIS REPORT –

From January 1, 200_ through December 31, 200_, the following claims payments were made in accordance with the Georgia Workers' Compensation Law:

1. YOUR TOTAL CLAIMS PAYMENTS $_____
2. **LESS** SITF 200_ REIMBURSEMENTS ($_____)
3. **LESS** OTHER THIRD PARTY RECOVERIES ($_____)
4. **NET CLAIMS PAYMENTS** $_____

Please answer the following:

1. Is your self-insured status approved by the Georgia Workers' Compensation Board? YES [ ] NO [ ]
2. Was your company self-insured for all of calendar year 200_? YES [ ] NO [ ]
   (*If yes, do not complete the following*)
3. Date your company commenced self-insured status during calendar year 200_. _____
4. Did your company cease self-insured status during calendar year 200_? YES [ ] NO [ ]
   If yes, date your company ceased self-insured status: _____
   Identify the insurance company: _____
   Effective date of coverage: _____
   Policy Number: _____

CERTIFICATION

I, _____, hereby certify that the foregoing is a true and correct report of the payments made by
(Printed Name)
_____, a duly qualified self-insurer under the Workers' Compensation Law of the State of Georgia.
(Company)
Furthermore, I am an official of said company in the capacity of _____ and am hereby qualified to sign this report.
(Title)

SIGNED THIS _____ DAY OF _____ 200_. SIGNATURE: _____

WITNESS: _____

PLEASE MAIL THIS ORIGINAL REPORT TO:
Subsequent Injury Trust Fund, 1720 Peachtree Street, Suite 500 North, Atlanta, Georgia 30309-2462

If you have a disability and need assistance completing this form, please contact the SITF ADA Coordinator.

Any questions related to this form should be directed to the Director of Administrative Services, Subsequent Injury Trust Fund, 1720 Peachtree Street, Suite 500, Atlanta, Georgia 30309. Telephone: (404) 206-6357. Fax: (404) 206-6363. TDD: 404) 206-5053.

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INSTRUCTIONS

The Subsequent Injury Trust Fund must receive the report no later than **March 1**. Late report penalties will apply when your report is received after March 1, even if you paid no benefits during this assessment year. Reports will be considered timely received by the Subsequent Injury Trust Fund only if they are actually received in hand on or before the required due date OR bear a valid *US Postal Service* postmark on or before the required due date.

"Claims payments" consists of weekly indemnity, lump sum payments, settlements, funeral benefits, medical costs, and rehabilitation costs.

LINE 1: YOUR TOTAL CLAIMS PAYMENTS

Report **all** payments you, as a self-insurer, made during the preceding calendar year, prior to any salvage. Include **all** amounts reimbursed to you over and above the self-insured retention. If you ceased self-insurer status within the (assessment) calendar year, you are required to report your claims losses for the full calendar year.

- DO NOT include legal or administrative costs.
- DO NOT include prior year SITF or Workers' Compensation Assessments you paid.

LINE 2: LESS SITF REIMBURSEMENTS

DO NOT change the pre-printed amount. The amount printed represents checks the Subsequent Injury Trust Fund issued from January 1 through December 31. This may differ from your figure if you did not deposit until January any reimbursement checks issued in December by the Subsequent Injury Trust Fund. If you do not agree with the pre-printed reimbursement amount, please contact the Subsequent Injury Trust Fund at the telephone number below.

LINE 3: LESS OTHER THIRD PARTY RECOVERIES

Deduct (if applicable) only Workers' Compensation payments you received from subrogation and/or refunds you received during this assessment year. DO NOT deduct payments you received from your excess workers' compensation carrier.

LINE 4: NET CLAIMS PAYMENTS

Subtract Lines 2 and 3 from Line 1.

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